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ABSTRACT

Primary prevention strategies (prevention at the community level) for disadvantaged populations are discussed. A number of factors in Canadian society have placed additional stress on many poor and working class families. These include issues of housing, unemployment, lack of education, and social changes with adverse effects on the disadvantaged. The impact of these issues is not limited to the children of the poor; being middle class is no guarantee that life will go well. Some disadvantaged children are sufficiently resilient to succeed academically and socially despite disadvantage. Resilient children have been shown to be social participators, able to accept authority, with the ability to concentrate and pay attention and an identifiable area of achievement. Factors that increase the likelihood of development of these traits include being healthy and of normal weight at birth, having an auspicious temperament, having "good enough" parenting, and living as part of a stable and cohesive community. Primary prevention is needed at the community level to encourage these factors. Some primary prevention projects have demonstrated their efficacy in freeing disadvantaged children from the worst effects of disadvantage. Twelve features of successful programs are outlined, and some exemplary programs are described. There will never be enough mental health professionals to treat all children with psychiatric disorders. The most senior and skilled professionals can be best used by using a consultee-centered and program-centered mental health consultation model to maximize the multiplier effect of such programs. Examples of effective and ineffective mental health consultation show how the efficacy of indirect interventions can be enhanced. (Contains 123 references.) (SLD)

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PRIMARY PREVENTION STRATEGIES FOR DISADVANTAGED POPULATIONS

Plenary Address to the

Ninth Canadian Ross Conference in Pediatrics:

The Health Needs of Disadvantaged Children and Youth

November 5 - 8 1992

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PRIMARY PREVENTION STRATEGIES FOR DISADVANTAGED POPULATIONS

Over the last several generations, child abuse has become endemic and systemic in our society. Everywhere we look, poor, middle-class, and rich children are failing to flourish. As a result, despite alarming increases in the cost of health care, we are facing today a general level of risk and neglect to the development and to the physical and mental health of Canada's children that would have been unimaginable in previous generations.

Ontario's Premier's Health Council, an independent group set up to advise the Premier of Ontario on the health needs of the province, has summarized and integrated a number of studies demonstrating the stunning effects of poverty and disadvantage on physical and mental health.

* The baby of parents living in a poor area of an Ontario city in 1986 was twice as likely to die in infancy than the baby of parents living in a wealthy neighbourhood. (1). Also the infant mortality of aboriginal children, among the most disadvantaged of all Canadian children, was approximately twice that of the total Canadian population in 1984, and the aboriginal stillbirth rate is three times that of the total Canadian population (2).

* The presence of poverty makes it more likely that other personal and situational determinants of parenting will act as risk factors rather than protective ones (3). Poverty creates its own risk factors (4), not the least of which is teen-age parenting (5) as well as aggravating pre-existing personal vulnerabilities (6) and undermining key sources of personal support (7).

* A 1989 review of the literature on early childhood interventions by the Ministry of Community and Social Services (Ontario) concluded:

"...The close association between poverty and risk holds for every component of risk - from premature birth to poor health and nutrition, from failure to develop warm, secure, trusting relationships to child abuse, from family stress to failure to master social skills. Programs aimed at any one risk will be helpful, but since coexisting risks interact, programs aimed at multiple risk factors should produce greater, more stable and longer term effects.....(It is a dangerous illusion to believe) that single, simple, relatively inexpensive one-shot programs can improve long-term positive advantages for economically disadvantaged children" (8; 9 - 15).

* In its document entitled "*The Determinants of Health*", the Canadian Institute for Advanced Research has noted:

> " The most dramatic historical improvements in the health of the average individual have been associated with increased prosperity.....the effect on the social environment appears to have been the key to changing the health status of the nation.....A large part of the effect (of this increased prosperity) appears through changes in the social and physical environment in which people live and work, and perhaps especially changes which give individuals a greater sense of belonging to a social group as well as control over their circumstances and fate (16).

But a number of factors are typical of our society in the 90s are placing additional stress especially on many poor and working class families, threatening to undermine their children's development and present a threat to our communities.. These include:

*** <u>Poverty</u>:** * In 1986, 1.1 million Canadian children less than age 18 (i.e. almost 20% of all Canadian children) were growing up in poverty, and this number, which had increased by 7% over the preceeding seven years, was chiefly concentrated in single-parent female-headed families, about half of which were living below the poverty line (2). Children are twice as likely as adults to be fed by foodbanks. (1; 17). Aboriginal families,

and also families headed by someone under age 25 were more than twice as likely to be poor; aboriginals' average income is a only a fraction of the national average (2).

* **Sense of exclusion**: Both Ontario's Premier's Health Council and the Canadian Institute of Advanced Research have demonstrated that the gap between rich and poor, even more than the degree of poverty, augments to role of poverty per se in undermining health and, the author would suggest, mental health (18 - 20). This is particularly well demonstrated in "The Determinants of Health":

> " We continue to observe, in nearly all developed societies, inequalities in health as measured by life expectancy, mortality, disability, or the incidence and prevalence of specific diseases. These inequalities are associated with social, economic and cultural factors." (19)

> " Research from a number of countries has found a clear association between social support networks and mortality, indicating that social relationships (or the lack thereof) constitute as well documented a major risk factor for premature mortality as smoking, hypertension, and other conventional risk factors." (21)

Nor is the answer to the ill-health associated with poverty and inequality to be found in increasing expenditure on medical services:

> " Health in human societies (as opposed to the course of individual cases of illness) is powerfully influenced by a nation's wealth creating capacity and the distribution of wealth - much more so than by the provision of medical care.....(in fact) inappropriate and increased expenditures (in health care) will act as a drag on a modern economy, reducing its overall efficiency and competitiveness for global trade and decreasing the capacity to create wealth." (22)

To illustrate this point, the CIAR uses the example of Japan, whose health care cost is among the lowest in the industrial world: 6.8% of the gross national product (GNP) as compared to 8.6% of the GNP in Canada, or 11.2% of the GNP in the United States. Even with so much smaller an expenditure on health care, and in spite of Japan's

physical environment which, at least in the cities, is poor, featuring all the stress and pollution that accompany severe overcrowding, the life expectancy in Japan has increased dramatically. The CIAR attributes this primarily to two factors. First, Japan has the fastest growing GNP of any major industrialized nation. Secondly, Japan has the smallest relative difference in income distribution between the top and bottom 25% of the population. This is but one example. In general:

> " There are rather strong correlations between the degree to which national income is equitably distributed and health status. For example, some less developed countries (eg Costa Rica; Sri Lanka; Kerala in India) have considerably better infant mortality and life expectancy rates than countries like Pakistan, Morocco or Afghanistan, which show on average much poorer health status despite similar per capita wealth." (23)

* **Lack of affordable housing**: Hewlett (24) reports that in the United States, from 600,000 to 3,000,000 people are homeless, with another 10,000,000 on the verge of homelessness of whom, in 1984, just over 30% were families with children. Homelessness in Canada is also a major problem; the Children's Aid Society of Metropolitan Toronto has recently taken into care each year one hundred and fifty children for whom the reason for apprehension was that their families found it impossible to house them despite paying, in some cases, up to 70% of their total family incomes for shelter. (25) Housing rates have risen so much faster than wages that these days most young families have to struggle to achieve adequate accomodation. If housing were again to consume 21% of the average 30-year-old's wages - instead of the 40% that it now does (26) - then, possibly, only the 13% of mothers who wish to work full time would do so, and many more parents, both mothers and fathers, would be able to choose to spend more time with their children (27).

* **Rising unemployment**: Numerous surveys have confirmed the World Health Organization's study in the 1980s that established that "High levels of unemployment and instability significantly increase levels of mental ill health, not just of the unemployed, but also of their families and the community in general" (18; 28 - 32). The unemployment

rate among Indians over 14 years of age is about 35%, and approaches 90% in some areas (2).

* **Functional Illiteracy:** A stunning increase in functional illiteracy is occurring at a time when, more than ever before, an adequate education is a prerequisite for obtaining anything but dead-end employment (24; 33). Fully 20% of adults in the United States are functionally illiterate, that is, unable to read and write at a grade 8 level (34). Functional illiteracy among minority youth in that country is estimated at 40% (35), while in Canada only about 20% of aboriginal children complete high school, compared to a national average of 75% (2). Hewlett (36) states that at a time when skill requirements and qualifications for even low-paying jobs are escalating throughout the economy, one in every three ninth graders in the United States is unable to make change for a two-item meal. Another indicator of the level of functional illiteracy is that in 1987, New York Telephone had to test 57,000 people to find 2,100 well enough educated for entry-level jobs as operators or repair technicians (37).

* **Rising rates of violence and abuse within families:** Child abuse has quadrupled since 1978. Studies and surveys across North America, have suggested that "a significant proportion of family life is punctuated with violence", and that children who witness spousal abuse or violence towards a sibling are more likely to become violent themselves later in their lives (86).

* **Rising economic necessity** (from rising recession and unemployment, and from costs going up as wages go down) that forces two parents to work to achieve a roof over their heads and a reasonable standard of living, often at soul- and mind-crunching jobs that keep them from spending time with their children, while providing little satisfaction but generating much tension and frustration, and undermining physical and mental health (38).

* **Unrealistic social expectations**, by which all aspire to a reasonable quality of life while more and more lack the qualities, skills and opportunities needed to achieve it. After all, if you aspire to "all that good stuff" you see on TV but are qualified only for a minimum wage job, the only way to get what you want is through crime.

* **Insufficient adequate daycare** to meet the need of children both of whose parents must work. This lack is greatest for disadvantaged populations in which sufficient adequate daycare could make the most difference, but working mothers of dependent children. earn, on average, only 46% of the male wage (39). There is no doubt that the need for daycare is increasing; in the United States, Hewlett points out that:

* 1950: 12% of preschoolers had working mothers
* 1990: 57% of preschoolers had working mothers
* 2000: (est) 70% preschoolers will have working mothers

ALSO

* 1976: 11% infants < 1 year had working mothers
* 1988: 51% infants < 1 year had working mothers. (40)

Every $1 spent on preschool education saves $4.75 - $6 downstream in lower costs for remedial education, truant officers, welfare and crime control (41 - 42). Also the enriched day care provided in the Head Start Program for disadvantaged preschoolers has been estimated by Weikart to provide economic returns seven times as great as the costs (43).). However, while in the mid 1980s all three levels of government in the United States were spending $263 billions/year on education of children age six or older, at the same time only $1 billion was being spent on children age 5 and younger (44). As a result, fewer than half American preschoolers were in nursey school, and, despite its potential savings, only

25% of those preschoolers eligible for Headstart could find a place in it (45). .

* The increased incidence of **social alienation and random violence**, often supported by gangs that serve as surrogate families for youngsters who have given up on the biological families who have consistently failed to provide the good-enough parenting that they need (46).

* The increased **reliance on chemicals** - alcohol, marijuana and hashish, cocaine and crack, and other street and inappropriately used prescription drugs - that are turned to as a temporary escape from lives seen, by those living them, as too full of tension, hassles and powerlessness, and too lacking in a sense of power and control over one's own destiny. The need to pay for these drugs and the effects of some of them also contribute to increasing the amounts of teenage violence and crime.

* The spectre of **AIDS**.

* The **breakdown of our major social institutions** in a society that increasingly pits moral values against material cost while having lost trust in our religious, political, academic and judicial institutions and, of course, in the media whose manufacturing and reporting of the news have become almost impossible to separate from the events that they are reporting (46). Just one topical and obvious example: the 1992 Republican presidential campaign in which Bush, who had consistently removed social supports from disadvantaged families, campaigned on a platform of family values.

* **Narcissism and moral blunting**. As we have given up on and withdrawn increasingly from society, the loss of faith in traditional values has left us obsessed with our own needs and aspirations, while blunting our responsiveness and sense of responsibility to our

communities and to our neighbours whose needs continue to go unmet (47). This has led to rampant narcissism and egocentricity - in which only we ourselves and our own needs count, and where commitment to others (including others in the family, without which families just don't work) has become a dirty word while freedom - instead of meaning as it does to Iris Murdoch (48) the British author and philosopher the freedom to love others - has become the freedom to abandon or exploit others if it suits one's own convenience. It has also contributed to our widespread tendency to blame the victim - the poor, the homeless, the mentally ill, the unemployed - because their misery makes us uncomfortable (49). This allows us, as a society, to ignore any responsibility for the plight of those who are crushed in the struggle to survive. Or, if we respond at all, we are likely to do so in minimal and patronizing ways that reinforce the recipients' sense of shame, worthlessness and exclusion. In this we behave more like the United States which marginalizes the poor than like the Western European democracies which include and support the disadvantaged as a matter of right and social justice.

* Our society's almost **absolute emphasis on human rights**, even when these are achieved at the expense of human needs.

These factors, especially when they coexist and potentiate each other, minimize many children's chances of obtaining from their families the security, continuity and quality of parenting that they need for optimal development. And it would be a major mistake to assume that, in the North America of the 1990s, it is only poor children who are disadvantaged. **Being a middle class child in the 90s is no guarantee that one will escape disadvantage, for the following reasons:**

* The **divorce rate** has risen to the point where there is now one divorce for every two marriages. As a result, children living in an intact nuclear family are no longer the norm, and by the late 1980s, nearly a quarter of children under age 18

were living with a single parent (50). Also, in the five years following a divorce, the woman's standard of living drops 30% while that of the ex-husband increases by 8% (51). Thus, as was stated at the Ross Conference in Pediatrics (1992): no child these days is more than a divorce away from disadvantage.

* Frequently adding to the risks associated with divorce are those contributed by **father abandonment**. A United States sample of 1000 children from families disrupted between 1976 and 1987 revealed that:

    * only 1 in 6 had seen their fathers once/week or more
    * only 1 in 5 had slept in the father's house in the last month
    * only 42% had seen their father at all in the preceeding year (52)

What is more, children with little or no contact with their fathers are unlikely to do well at school (53; 54), and children of two-parent families are almost twice as likely to be high achievers in school, and only half as likely to be low achievers, as than those from single-parent families (55). Also, fathers' involvement is more important than that of mothers in protecting children from youthful drug use; children with firm but not coercive fathers are only half as likely (18%) to become substance abusers as children from single-mother homes (35%) (56).

* The combination of fathers spending more and more time on the job, the shift of mothers to the work force, rising separation divorce and the effects of father abandonment have led to what Mattox has termed the "**family time famine**" (57). The participation in family life of most parents - that is, the proposrtion of adult life spent with children - has declined precipitously from 62% in 1960 to 43%, the lowest in the history of the United States (58). Between 1960 and 1986, there were 10 hours less per week of potential parenting time, and the decrease for black families was about 20% higher (59). Also, the amount of

"total contact time" (i.e. the amount of time that parents spend with children while doing other things such as shopping, visiting grandma, etc.) has declined by 40% (57). The significance of this is that the more hours that children spend unsupervised after school (unrelated to sex, race, family income, academic performance or number of parents in the home), the greater the risk of substance abuse (60). Decreases in the average time spent doing homework (61) and increases in the amount of time spent watching television (62) are both correlated with a lack of parental supervision and with indifferent or poor school performance.

For all the above reasons, singly or, even more, in combination, middle and upper class as well as poor children are vulnerable to disadvantage.

But not all children growing up in disadvantaged circumstances have their development undermined by their situation. **Kellam (63) has identified four characteristics of those children who were sufficiently resilient to succeed academically and socially in spite of disadvantage. These survivors:**

* **were social participators**, neither excessively shy and inhibited nor overly aggressive. (This suggests that in addition to whatever role their temperaments contributed to their resilience, they were more likely to have had sensitively attuned mothers and to have been securely attached).

* **were able to accept authority**. (Those children unable to do so had problems in relationships because of their inability to control their aggression).

* **could concentrate and pay attention**. (A function of impulse control, this was a prerequisite for school success).

* **had identifiable areas of achievement**. (The fact that they had acquired skills suggests some degree of frustration tolerance, and the achievement provided a source of confidence, self-esteem and approval by others).

But if these are the characteristics of resilient children, what factors can increase the likelihood of resilience and success for children growing up in disadvantage?

1. Normal birth weight. The best predictor of an infant's survival is its weight at birth. The medical and neurological hazards of low birth weight are well recognized (2). Low socioeconomic status, along with having a mother who is (a) unmarried, (b) a teenager, and (c) poorly educated, (d) malnourished (e) receiving poor prenatal care and (f) a heavy smoker all increase the risk of low birth weight (2; 64). Social conditions and smoking are thought to be the principal factors implicated in low birth weight. Prenatal programs to prevent low birth weight by improving the nutrition and the care of groups of mothers at high risk have produced unmistakable long-term gain.On the other hand, women who receive poor prenatal care are three times as likely to have premature (low birth weight) babies (65).

2. **An auspicious temperament**. The role of (inherited) temperament in exposing some infants to more anxiety and stress (66; 67), and others to stressful parent-child relationships, to impaired attachments and to diminished competence has been convincingly demonstrated (68 - 73).

3. **Good-enough parenting**, when present, is a major factor buffering the the effects of disadvantage.

Factors that contribute to making parenting good enough include:

(a) **A secure attachment.** Despite the lack of a straight-line relationship between attachment, as measured in the laboratory by Ainsworth et al (74), and good emotional health and social development, there can be no doubt that the lack of a secure attachment can undermine development and adjustment, especially when associated with other risks (75). When present, a secure attachment can provide security, confidence, the capacity for trust and for relating succesfully to others, all qualities that will enhance a given infant's resilience (76 - 78).

(b) **Continuity of relationship** with major caregivers. The continuity of the young child's relationship with major caregivers is crucial to the child's sense of security, to the development of a sense of trust, and to the formation of identifications that provide the foundation of an effective conscience.

(c) Adequate and appropriate early **cognitive stimulation** is crucial for language and cognitive development, so necessary for achieving competence and emotional and social potential. When the child is older, cognitive stimulation consists of encouraging the child to express his views and to negotiate with others. When encouraged, this has the effect of increasing social responsiveness and general competence, especially in boys for whom it serves as a socially acceptable release of aggression (79).

(d) **Sufficient and appropriate structure**. This is essential to the child's security, both by protecting the child from danger and by helping him learn to contain - and thus control - his own impulses, that is, soothe himself. This is crucial for the control of anxiety and aggression, which in turn is associated with the ability to tolerate frustration and to focus attention (79 - 80).

(e) **Freedom from rejection.** A sense of being valued is the basis of the child's self- concept and the source of essential self-esteem (78).

(f) **Freedom from abuse, violence or chronic discord** in the family. All of these behaviours are associated with higher levels of aggression in children, and a diminished ability to contain or succesfully control it, thus predisposing children to the development of conduct disorders (81 - 86).

(g) **Consistency of expectation** between caretakers, and reasonable consistency between verbal and behavioural expectations. These are conducive to the development of impulse control and the internalization of values, but are commonly absent in response to chronic marital conflict featured by polarization of the parents and breeching of the intergenerational boundary.

(h) **Transmission of the values of the culture**. Members of families alienated from society as a whole will not identify with or feel bound by the rules or values of society (46). This, of course, is a major issue for cultural or racial communities, including those living in what Lewis (????) called the "culture of poverty" or what today we are more likely to call the permanent underclass (33).

4. **The general stability of society**. The less stable our communities, the greater the pressure on parents to provide optimal involvement, stimulation and structure within the family in order to avoid family breakdown and to produce competent children (88 - 89).

The Ontario Health Study has demonstrated that while 18.6% of Ontario's children and adolescents have at least one psychiatric disorder - and the majority of these have more than one - only one in six of them receives it (17). It is unrealistic to think that there will ever be - or that we as a society could ever afford - the professional resources to treat all such children and their families. This points to the need for a systematic commitment by society to primary prevention at the community level, one focused on

increasing the resilience and bolstering the competence of known high-risk populations. Such programs will be directed towards entire populations at risk, not at individuals or families already identified as having a disorder. **What characteristics, then, are common to primary prevention programs that have been proven to work?**

Successful prevention programs have begun by pinpointing those causative factors most accessible to change. Rutter et al have shown that the total effect of a number of simultaneously acting stresses is greater than the sum of the effects of the stresses acting individually (90). He has demonstrated that there is a threshold beneath which the cumulative effect of co-existing stresses can be tolerated by most individuals, but above which only the most resilient avoid developing a disorder. This suggests that we focus on eliminating, neutralizing or compensating for those stressors we are able to counteract, in order to lower the total stress level experienced beneath the threshold of tolerance. This we can do best by concentrating our efforts on those factors accessible to modification.

Many of the most powerful determinants of unfavourable outcomes are related to poor social conditions. Schorr's excellent review of prevention projects whose success has been empirically proven (33) has shown that it is often possible to unlink children from the undermining effects of poverty and disadvantage, thus interrupting generational cycles through programs that meet the following criteria:

(1) **They are broad-based.** Based as much as possible on the better integration and more efficient use of services already available but across usual service lines, they offer a coherent and comprehensive mix of services directed towards whole populations at high risk rather than just towards previously identified patients or families.

(2) **They are well integrated.** The component services are accessible at the point of service delivery so that a project coordinator can quickly mobilize a variety of resources

-- child welfare, housing, financial, employment, public health, recreational, legal and mental health services -- across usual service lines. Practitioners from these varied sources may have to transcend the limits of any single agency's autonomy and must function as members of a team. This takes time, training, openness, and, frequently changes in funding patterns which, as they are, frequently actively discourage such collaboration.

(3) **They are well orchestrated.** A project coordinator orchestrates and sees to it that those services needed are provided. The participating services and agencies are committed to cooperating with the project coordinator and with each other. The coordinator will inform the community or group at risk about other potentially helpful services and how they can be found, serving as a broker when necessary to help link the client group with the needed services.

(4) **They are neighbourhood-based.** Successful preventive programs provide services in the community's home ground, instead of waiting for the community to come to the hospitals or agencies which disadvantaged populations often seem to find intimidating and/or inaccessible (91).

(5) **They are systemic.** Successful preventive services address their programs not to children or parents alone, but to families and groups of families at a two or three-generational level, and to beleaguered communities. (43)

(6) **They are advocates.** They are ready, when necessary, to advocate the interests of their client group or community in dealings with agencies, schools, governmental or other social institutions.

(7) **They are available**. Front-line staff have both the commitment and the time available -- and that means very limited caseloads -- to build the necessary relationships and maintain them long enough to do the job properly.

(8) **They are empowering**. Workers in successful prevention programs must have the personal qualities and professional skills needed to empower the client communities, since empowerment is one of the key dimensions of successful prevention.

(9) **They are funded separately** from other services provided by the participating agencies. Unless they are, experience has shown that they will be the first programs to be diluted or dropped when the agency reaches a financial or manpower crunch.

(10) **They are accountable**. There is often an inherent conflict between the need for creativity and flexibility on the part of service deliverers and the demand that programs meet rigidly defined standards of accountability while satisfying narrow definitions of professionalism and demonstration. Many successful programs are out of synch with bureaucracies and major systems such as funding sources; assessors of accountability; demands for service equality for the whole community. Unless such a mismatch can be corrected, we will continue to see pilot projects, whose success had been well documented, either succumb to being gutted through dilution of the rigorous criteria that made them successful in the first place, or discontinued altogether. Professionals and ministry planners will have to cooperate to develop the incentives and regulations needed to effect change. These must be strong enough to be effective, but not so rigid as to discourage creativity and local variations, as long as the programs meet preset outcome goals. These goals and the built-in evaluation procedures should be persuasive in demonstrating the effectiveness and in defining the enduring attributes of each itnervention.

(11) **They are not cheap**. While in the long run..good preventive programs can demonstrate that ultimately they save money for the community, the intitial cost of establishing them may be considerable, and some of the long-term benefits may not be realized for years (see also 15).

(12) **They are persistent**. Involvement over time gives credibility. Generally, though not exclusively, preventive services will be organized along the lines of the following models:

(I) PRENATAL/PERINATAL INTERVENTIONS - The medical, neurological and developmental hazards of low birth weight are well recognized (2; 65). Socioeconomic disadvantage, especially when combined with ahveing a mother who is (a) unmarried, (b) a teenager, and (c) poorly educated, all increase the risks of low birth weight (64; 92 - 94). . Prenatal programs to prevent low birth weight by improving the care and nutrition of mothers at risk have produced unmistakable long-term advantages (2; 92).

Schorr (33) has reported on how good programs for poor, teenage, unmarried, poorly educated mothers have succeeded in reducing the incidence of prematurity and low birth weight. The program coordinator, possible a pubnlic health nurse, a street worker or an ethologist, "joins" a high risk community, gaining the trust of the local teenagers and using that rapport to motivate the teenage expectant mothers to have healthier babies. This may be done by home visits to known pregnant teenagers, by spending time at teenage hangouts, or by setting up a prenatal clinic where and when pregnant teenagers would be most! likely to use it, possibly in the early evening or, in some communities, even later at night depending on the habits of the target population (91).

The goals of such a program might include: improving diet; decreasing drug and alcohol use during pregnancy; providing regular prenatal care; increasing expectant mothers'

awareness of their infant's needs for attachment and stimulation; helping new mothers interpret their baby's signals and develop confidence in their ability to meet their baby's needs; encouraging the mothers to remain in school and helping the school support them to do so, in order to avoid the secondary trap of chronic economic dependency and poverty. The program focus would have to remain flexible enough to respond to what the clients saw as their needs, whether or not these were specific to the pregnancy.

One such program that has demonstrated its effectiveness is the Nurse Home Visitor Program in Elmira, New York, described by Olds et al, (95). The "Healthiest Babies Possible" program operated since 1979 by the City of Toronto's Department of Public Health is an excellent local example (96).

Project STEEP (Steps Toward Effective, Enjoyable Parenting) was a program developed by Egeland and Erickson (97) "to promote healthy-parent-infant interaction and prevent social and emotional problems among children born to mothers at risk for parenting problems (i.e., due to poverty, youth, lack of education, social isolation, and stressful life circumstances". Based on home visits by "family life facilitators", the program starts in the second trimester of pregnancy in order to minimize stigma, and to improve the care and nutrition of the at-risk mother. The visits continue biweekly until the babies are a year old. Prior to delivery, the facilitators help the mothers deal with their feelings about their pregnancy and help them prepare for parenting. Once the babies are about four weeks old, the same facilitator also conducts biweekly sessions with groups of eight mothers and their babies. She uses the groups to provide basic knowledge about infant development and to sensitize the mothers to their own babies' cues, signals, and special needs through demonstration and actively involving them and their babies rather than through lectures, to help increase their comfort and responsibeness. A specific attempt is made to help each mother recognize painful feelings and resolve relationship issues left over from the past, and to realize how her past experiences are affecting her interactions with her baby. From

the start, the facilitators work to establish and maintain a trusting relationship with their clients, and to empower the mothers by helping them manage both theri parenting and other aspects of their lives more effectively.

(II) PRESCHOOL INTERVENTIONS. The Perry Preschool Program (43) is one of several model programs that have provided the experimental basis for the Head Start program. It followed at age 19 five groups of poor children who randomly assigned either to an enriched preschool program or to a control group. In early childhood, the enriched group performed better intellectually than did the control children. In public school, the enriched children showed better achievement and adjustment. By adolescence, those from the enriched preschool program had a higher rater of high school graduation, less delinquency, less unemployment, less drug abuse and less teenage pregnancy.

This program utilized enriched day care services, usually located in or near the schools, and featured an adequate and stable (over time) staff of skilled workers to provide the nurturing, stimulation, structure and continuity that high-risk children particularly need if they are to compensate for the frequently inadequate parenting received in disadvantaged and/or marginally coping families. The location also made it easier for teenage mothers who kept their babies to continue their education, thus protecting their potential for economic self-sufficiency. (See also 98; 99).

(III) SCHOOL-BASED INTERVENTIONS. Enriched community schools in high-risk neighbourhoods, especially in kindergarten and the primary grades, can provide the stimulating and supportive alternative environment that can make the difference for many children of disadvantaged families. Such schools can help children feel secure, respected, challenged and cared about. Their teachers and parents work together in school-based management teams. Instead of the conflict so common between parents and teachers in

disadvantaged neighbourhoods, these parents and teachers share the task of preparing the community's children for life.

Such schools recognize the needs and strengths of children who have virtually raised themselves and, possible, one or more siblings and parents along the way. They do not respond to such children's initial inability to surrender their need to be in control -- the need which has previously been integral to their survival -- as if it were intended as a challenge or an attack (91). Such schools have been shown to protect ongoing development and socialization despite the frequently undermining effects of other family and communal stresses (100). Educators in such programs stress the need for mental health professionals working alongside teachers and aprents, rather than merely removing, trying to treat and, thereby, segregating and colluding in the most scapegoating of difficult children. Families that benefit most from such programs are ones in which the mother was an active volunteer in parent/teacher liaison activities. The commitment and effectiveness of the school principal is, of course, crucial to the success of any such program. The work of Rutter and his colleagues (100) and that of Comer (101 - 103) and Elias et al (104) provide excellent illustrations of how to organize such programs and what makes them successful, as well as demonstrating how the originators of the programs have established their effectiveness.

(IV) **PREVENTIVE INTERVENTIONS FOR CHILDREN AT RISK OF COMING INTO CARE.** Various types of preventive services have shown that they can keep children out of care (33 and 110; see also 105 - 109). All such programs have required an extensive and expensive initial investment in workers' time and services -- at times up to one hundred hours/case during the weeks of acute crisis. In order to achieve this worker availability, the Homebuilders program, arguably the most effective primary prevention program in the child welfare area, assigns only three cases to each worker, and may initially assign two workers to a case to ensure that all family members get the attention

they need until the family crisis is brought under control (109). The core worker addresses the multiple needs of the family as the family defines them, co-opting and brokering a variety of servcies from cooperating agencies and institutions when needed.

Successful prevention programs in this area are not restricted to a limited intervention directed, according to plan, towards a single aspect of the total system in crisis such as just the mother's need for support, just the child's behaviour problems, just dysfunctional communication and problem-solving within the family, just problems with the school, etc. In addition to providing and coordinating an adequate mixture of services, other factors that may improve the effectiveness of a prevention program may include: The timing of the intervention (i.e. could better results be achieved by offering a program before the situation reaches the point where a child is on the verge of being taken into care?); the duration of the program (does premature withdrawal of an effective service contribute to many children unnecessarily coming into care? (107); the degree to which it empowers previously overwhelmed clients to take control of their lives. Although no preventive program will totally succeed in keeping children out of care, in its first six years of operation, Homebuilders rendered placement unnecessary for 92% of eligible client families which, among them, had 849 children originally considered for an out-of-home placement, although Cameron and Bidgood (110), while not denying the effectiveness of the program, have critically examined and questioned some of the claims made for its efficacy.

Early Intervention and the Consultative Model

However, despite the promise of effective prevention programs like those profiled above, it is not a simple question of which is needed, treatment services or prevention programs. Obviously, both are necessary (14; 15; 33). While more common in disadvantaged populations, psychiatric disorders are, of course, not confined to them, and the suffering

and wastage of biologically and/or environmentally disadvantaged children who develop disorders may well need treatment. If they do, the sooner they are diagnosed and an appropriate intervention is begun, the less complicated the problems are likely to become, and the more likely the case is to respond to intervention within a reasonable time.
The key to early diagnosis and intervention lies in sensitizing those professionals in a position to observe large populations of children before they have developed entrenched disorders. At some point in the future, this might in part be achieved during the professional training of family doctors and public health nurses, day care providers, teachers and other school staff, and workers of Children's Aid Societies. In addition, however, better early recognition and management can be assisted through the regular and effective use of mental health professionals as consultants on site in neighbourhood centres or agencies where large groups of children at risk are to be found. In that capacity, they can serve three key purposes. First, they can sensitize the staff of those agencies to recognize early signs of abnormal behaviour and/or disorders. Second, they can improve the staff's management of disorders, both by cultivating attitudes of enquiry and by teaching them how to form and verify hypotheses as to the reasons for problem behaviours, and by helping them develop ways of "treating" the child either directly or indirectly (through working with the parents) in order to improve the situation. Third, they can recognize when the problem is more than can be dealt with adequately in the primary setting, and, when necessary, can assist in making a referral to a clinical setting. Later, they can assist by interpreting recommendations from clinicians or from mental health centres to the staff of the primary setting, and helping them develop strategies for intervention based on those recommendations.

The professional literature overwhelmingly suggests that most highly trained mental health personnel can do more for community mental health by providing consultation to front-line services reather than by spending all their time in direct (i.e. one-to-one treatment. This service pattern, which has been termed the "multiplier effect", can benefit consultees,

consultants and, expecially, clients as well as the community, provided that a successful partnership between the consulting professionals and the consultee services can be established and maintained. Such service integration implies that both consultants and consultees have their own areas of expertise, and that many cases or situations can be better managed through ongoing interagency collaboration and/or a process of mental health consultation than through referral from the front-line service to a clinical setting. Failure to define the potential contributions of each partner to the consultation process can lead to inappropriate expectations and avoidable frustrations of one partner by the other, and to poor coordination and collaboration between services.

I have discussed elsewhere in some detail the role of mental health consultation within the child welfare system, describing a variety of formats and their relative advantages and disadvantages, potential benefits to children's aid societies, and problems that can limit the effectiveness of the consultation (Steinhauer, 111). I also explored in some detail, the frequency with which children's aid society workers have unrealistic and excessive expectations as to how much children stand to benefit from psychotherapy; Criteria for children in care for success in one-to-one psychotherapy; limitations of psychotherapy for this population; common problems in attempting to treat foster children in individual psychotherapy, especially in a private practice setting, and ways of minimizing these; the relative merits of a mental health professional working in a consultative as opposed to a direct service model within the child welfare agency; and strengths and weaknesses within the working relationship between consultees and consultants. One common argument against the position I have espoused -- that mental health professionals are merely promoting the consultative model to rationalize their avoidance of great involvement in such unrewarding and difficult -- cases is also discussed (112). Much of what is said in this review of consultation within the child welfare system is equally true of attempts to treat disadvantaged children currently involved within the day care or educational systems.

Not all mental health professionals, however, not even those who are experienced and who possess considerable expertise as therapists, are necessarily equipped to provide effective mental health consultation. Before doing so, they will have to learn to adapt their knowledge and skills to the context and problems of the consultee service or agency.At the same time, agencies may have to learn better ways of training and using their consultants more effectively. In a recent survey of staff working in seven service sectors, the Consultation Task Force of the Sparow Lake Alliance -- an organization to be described later in some depth -- found that consumer agencies were quite consistent in what they considered the characteristics of effective and ieffective consultants (113). These are summarized in Table I.

TABLE I: CHARACTERISTICS OF EFFECTIVE AND INEFFECTIVE CONSULTANTS

EFFECTIVE CONSULTANTS	INEFFECTIVE
Suit consultation to needs of consultee/agency.	Impose own ideas of how consultation should go on consultee/agency in an authoritarian and/or rigid manner.
Provide concrete and practical recommendations when needed.	Remain theoretical; offer nothing practical or concrete.
Reliable; committed.	Unreliable; uncommitted.
Speak the language of the consultees.	Too theoretical and/or too much jargon. Don't speak the language of the consultees.
Sensitive to the context and the problems of the agency, and able to accommodate to them. Can rely on consultees to orientate them to what the the agency can/cannot do.	Don't appreciate the differences between what can be done in a treatment centre (with a selected client population) and what is practical in a child welfare agency or school. e.g. "It didn't help for him that what this unreliable, single mother of three young children needed was individual psychotherapy three times/week".
Can acknowledge the limits of his/her own knowledge and understanding.	Knows all the answers.
Respectful of consultees' areas of expertise.	Dismissive or disrespectful of expertise and experience of consultees.

Let me give two case vignettes that can illustrate the role that a mental health consultant can play in a non-clinical setting.

I. A child psychiatrist spent one-half day weekly consulting to an outreach program in an inner city public school situated within an area of great cultural diversity. This school served a large public housing unit with a high rate of crime and drug use. Many of the students came from broken and/or violent families, and were poorly prepared, both academically and socially, for school entry.

In the outreach program, the psychiatrist worked as part of a team, along with the school's principal, a supervisor from the Children's Aid Society, a community worker and other members of the school staff who attended around specific issues or children. The program was designed to sensitize classroom teachers to the social and emotional needs of the children, and to help them learn to manage better these often disruptive, aggressive and disturbed children in and out of class. Furthermore, the program reached out to the community in an attempt to involve the parents in a partnership with school staff for the education of their children.

Were the psychiatrist to spend the same amount of time treating individual children in her private office or clinic, she would have been able to treat three, or, at best, four patients on an ongoing basis. Consulting to the outreach program, however, she was able to affect indirectly the attitudes and behaviour of some 200 high-risk students over the school year. In addition, through her ongoing involvement with the teachers, she will exert an influence not only upon those students about whom she and the teachers talk directly, but on all the students in those teachers' classes. Even more important, in the long run, will be

the carry-over effect on other children in future years to whom those teachers will have been sensitized through their involvement in the program.

II. As part of an empirical comparison of two different models of foster care (114), the author spent two hours once each month consulting to the co-leaders of four groups of foster parents who, among them, cared for 59 children between the ages of four and seventeen, most of them severely disturbed. These meetings, originally planned to coordinate the service and research components of the project, were primarily used to provide a program- centred consultation to develop the understanding and intervention skills of the group leaders. It helped them make the shift from mere descriptions of incidents reported by the foster parents to grasping the underlying themes and patterns that those incidents represented, and increased their repertoire of techniques for intervention within the groups. Since many issues discussed were generic to foster care rather than limited only to the groups' functioning, the leaders generalized what they had learned from the consultations and applied it to their other cases as well. Surely, from the community's point of view, this was a better use of the psychiatrist's time than if he had seen two families in assessment or treatment in the same length of time.

Prognosis for Direct Treatment of Established Disorders in Disadvantaged Families

With enough therapists available to see only one of six children who need treatment directly (17; 115), it makes sense to reserve one-to-one individual psychotherapy or family therapy for those cases having the greatest chance of being treated effectively (112). Despite a relatively high incidence of psychiatric disorders in members of disadvantaged families, few of them are good candidates for the traditional psychotherapies, for the following reasons:

(1) Generally speaking, disadvantaged families are likely to have multiple interconnected problems (116). The combined weight of the socioeconomic and psychosocial stresses pressing on these families is usually so great that they rarely have the organization or the energy to enter into or remain involved in the usual forms of individual or family therapy (117). They rarely keep regular appointments (118 - 21).

(2) Disadvantaged families as a group tend to avoid sitting down and talking about feelings. In fact, for at least the males within this population, to acknowledge problems or to discuss feelings is often seen as a sign of weaness, if not of effeminacy.

(3) Most disadvantaged familites, because of the number and severity of their problems, their tendency to easy discouragement and giveing up in response to frustration, and because they are so highly oriented towards immediate results rather than towards planning and working now for future gains, are unlikely to remain in psychotherapy long enough to derive much benefit (122).

(4) Psychotherapy with the children of disadvantaged families is often made much more difficult by the inability to involve the family -- meaning, by that , the not-always-stable unit that is living together -- as an essential component of the treatment. Dysfunctional families frequently see themselves as playing little part either in the maintenance or in the solution of their children's problems. When that is so, it is unlikely that one or two hours a week of psychotherapy, to which the parents are either disinterested or resistant, will effect significant change in a child who, for the rest of the week, is under the influence of a highly dysfunctional family system that is reinforcing the child's psychopathology.

(5) Children of disadvantaged families are frequently more oriented to acting than they are to talking, and they are more likely to discharge intense or conflicted feelings through

behaviour than they are to internalize them to utilize fantasy as a defense to help contain them, or to verbalize them as a way to deal with the problem.

It should be acknowledged right from the start that primary prevention, at least at first, is not cheaper than secondary prevention (active treatment) or tertiary prevention (long-term, management). In fact, since the long-term effects of primary prevention are often a long time in coming, the initial cost (i.e. front-end loading) may temporarily increase costs to the community. For that reason, primary prevention must be sold on the grounds that it helps "level the playing-field" (32), thus getting all children off to a more nearly equal start, and on the ability of such projects to reduce the burden of suffering. It is, however, already possible to demonstrate, through well-evaluated programs already reported in the literature, that effective primary prevention programs can protect children's potential for normal development. In the long run, they can provide a source of significant saving for the community -- both in economic and in human terms -- if they successfully achieve their measurable objectives (16; 24; 33). For child psychiatrists and clinical psychologists to improve the development, promote better mental and physical health and decrease significantly the damage done to disadvantaged children, they will have to increasingly move beyond their offices and hospitals and go beyond traditional patient-centred psychiatric interventions to work within coalitions that go beyond narrow definitions of mental health, coalitions centred in schools, day care centres, Children's Aid Societies and in high risk communities.

Finally, it is not a question of what is needed, treatment services or prevention programs. Obviously, both are required. While more common in disadvantaged populations, psychiatric disorders are not confined to these groups, and the suffering and wastage of those biologically and/or environmentally vulnerable children who develop disorders in the absence of disadvantage are no less worthy of effective primary and secondary interventions than are those growing up in poverty (24; 123). To deprive badly needed

treatment resources of their funding in order to finance the primary prevention programs described above would be robbing Peter to pay Paul. However, there is a wealth of literature suggesting that both the child welfare and children's mental health systems could be both more effective and more cost-efficient if what has been empirically proven was generally understood and systematically applied in the development and delivery of services within the two systems (16) (24) (33).

What is needed is for service providers from a variety of disciplines and planners from a number of ministries with overlapping responsibilities (i.e. health; community and social services; education; attorney-general) to work together across traditional service lines on a basis of trust and mutual respect. We need to develop and evaluate model programs based on the empirical and clinical knowledge currently available but adapted to the resources and needs of the local scene. We need guidelines for the more selective use of such programs, and realistic ways of establishing their effectiveness. We need better ways of empowering both those who have given up trying because they have lost hope and those who burn out trying to help them, because they are so overburdened and lack the professional back-up and community support they need to feel that what they are trying to do matters. When are we, as a society, going to learn that ignoring the problem, blaming the victim, and attempting to rely on the suppression of those who are falling farther and farther behind no more serves the community's interests than it does the interests of those who, repressed by the community from which they have become alienated, can see only two alternatives: giving up and becoming chronically dependent, or declaring war on the society they hold responsible for their hopelessness and sense of exclusion

PRIMARY PREVENTION STRATEGIES FOR DISADVANTAGED POPULATIONS

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